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District Nursing

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EDITORIAL

HOW much of a district nurse's time would a central sterile supply service save? A time and motion study to find out, planned in conjunction with two local health authorities, is part of a survey the Queen's Institute is undertaking on central sterile supply services and their application to district work.

These services, more common in America, do exist in some hospitals in Britain, and the past year has seen a growing development of them. Some local health authorities have provided a central service for autoclaved syringes for a number of years and one is now also catering for sterilised instruments. Others are considering the best way of organising sterile supply services, and it is to help these and all others interested that the Institute is carrying out the survey with two of its nursing officers, one operating in the north and one in the south.

They have already started intensive work on the subject. Some of their findings, if not their final conclusions, will be announced at a conference which the Institute is holding on 19th April and at which Dr. E. M. Darmady, whose service at Portsmouth is reported on page 224, will be the principal speaker. Further details will be announced later.

The problem of cross-infection—one of the chief reasons for central services in hospitals—is not one of great concern on the district. But a second reason particularly applies on the district: the saving of nurse-power. The average nurse has to spend too great a proportion of her time on sterilising. A central supply service of sterile dressings, syringes and other equipment would leave her more time for nursing her patients. With the current shortage of nurses, those who are available should be relieved as far as possible from mechanical procedures in the background.

One problem, particularly in rural areas, is likely to be the question of distribution. But if central sterile supply services are provided, arrangements must be made for delivery of the supplies to the district nurse. If she is left to fetch and carry for herself, the whole object of the exercise—the saving of her time for more direct nursing treatment—will be defeated.

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The Portsmouth service was the starting point for the survey now being carried out by the Queen's Institute. We hope that this brief report will provide a useful introduction for readers who are not familiar with central sterile supply services, and that it will promote study and discussion on ways of applying them to district work

Portsmouth Central Sterile Supply Service

A CENTRAL sterile syringe supply service was started at St. Mary's Hospital, Portsmouth, thirteen-and-a-half years ago by Dr. E. M. Darmady, when he took up the appointment of senior pathologist of the Portsmouth and Isle of Wight Area Pathological Service.

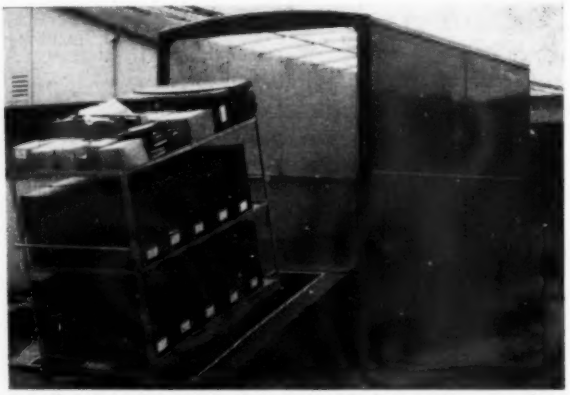
Guided by the experience gained through this service, and after visiting hospitals in the United States of America, Dr. Darmady and his colleagues instituted a central sterile supply service in Portsmouth nearly two years ago. Originally, the service worked from two departments, one for St. Mary's Hospital (700 beds) and another for a second hospital which was the main accident centre (250 beds). The service was, however, soon centralised in one place: a one-storey prefabricated building used as a war-time nurses' home at St. Mary's.

Surveys had shown that standards of sterility in hospitals were not satisfactory. Dr. Darmady quotes an instance of twenty per cent of Cheatle forceps and twenty per cent of dressings in drums on the wards being infected. The C.S.S. service therefore aimed to improve the technique and standards of sterilisation, to reduce cross infection, and to save the time of nursing personnel (in the St. Mary's group, a nurse was spending 2½ to 3 hours a day preparing and sterilising dressings and instruments).

The sister-in-charge of the C.S.S. department is a state registered nurse with theatre experience, who has been with the department since its inception. The department is staffed by orderlies and part-time drivers, and works a seven-day week.

A survey conducted before the service started showed how many syringes, dressings and instruments each ward used, and allocations were based on these figures. The syringes are supplied in standard boxes each with spaces for different sized syringes. Dressing and instrument packs are supplied in panniers, special suitcase-type carriers with partitions. Panniers and boxes are exchanged each day, so that one is always on the ward while a second is being re-charged in the C.S.S. department. (Although we quote one, this figure is of course increased as the size and type of the ward demands.)

A large surgical ward needs three panniers. Aluminium partitions provide pigeon-holes for different packs. The box holding syringes is in the centre pannier



A trolley-load of panniers about to be wheeled up the ramp of the specially-designed lorry

Panniers are stacked on trolleys, which are loaded direct from the C.S.S. department into a specially-designed lorry with a tail-board which lets down to form a ramp. They are then delivered to various hospital wards (the service at present supplies 8,000 beds) by one of the orderlies.

Five basic-dressing packs are supplied by Johnson & Johnson (see opposite for those supplied to female ward). These basic packs are supplemented by others prepared in the C.S.S. department. The dressings, etc., are wrapped in a paper towel, which is used as a sterile field for the dressing procedure. The outer cover is a Kraft-paper bag, sealed with heat-sensitive tape.

Instruments are packed in similar bags, in nylon film, or in aluminium containers with foil tops on the same principle as syringe containers. As much equipment as possible is disposable. For example, Prestige aluminium pudding basins, cake tins and individual patty pans have replaced steel and enamel receiving bowls, kidney dishes and gallipots.

Dressing and instrument packs in paper and nylon are sterilised by autoclave. Aluminium containers are sterilised by dry heat on the moving belt of the infra-red steriliser.

FEMALE WARD
CONTENTS OF DRESSING PACKS
Supplied by Johnson & Johnson

No. 1 Large Dressing Pack
10 Cotton wool balls
4 Gauze squares 3″ × 3″
2 Cellulose squares
1 Gallipot
1 Large dressing towel (clinical sheet)

No. 2 Small Dressing Pack
4 Cotton wool balls
2 Gauze squares
1 Gallipot
1 Dressing towel (small)

No. 3 Vaginal Pack
8 Cotton wool balls
1 Zobec 3″ × 3″ gauze square
1 Sanitary pad
1 Large clinical sheet

No. 4 Skin Preparation Pack
6 Cotton wool balls
2 Gallipots
2 Dressing towels (large)

No. 5 Swab Pack
6 Cotton wool balls

Supplied by C.S.S.D.

Sanitary Towel Pack
1 Sanitary towel

Glove Pack (Paired)
2 Rubber gloves

Cellulose Pack
1 Cellulose square 9″ × 9″

Gauze Pack
5 Zobec gauze squares 3″ × 3″

2 Swab Pack
2 Cotton wool balls

Incontinent Pads
1 per pack

Glove Pack (Single)
1 Rubber glove

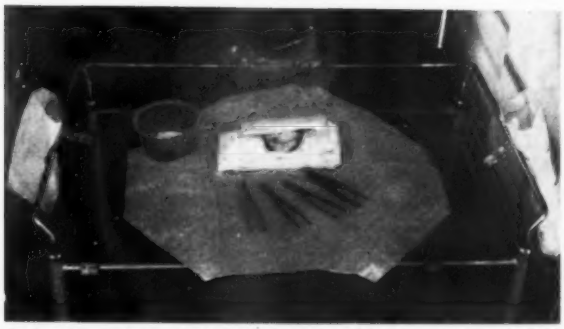
Towel Pack
2 Clinical sheets

Cut-down Pack
1 Bard Parker blade } in aluminium container with green cap
1 matching handle }
2 prs. mosquito forceps
1 pr. toothed dissecting forceps
1 aneurysm needle
1 straight needle } in aluminium container with red cap
1 curved needle }
1 gallipot
nylon thread
4 cotton wool balls
2 gauze squares
1 small clinical sheet
2 Polythene adaptors sizes 1/2 & 3/4—in aluminium container with gold & green caps

NYLON PACKS CONTAINING INSTRUMENTS ETC.
Packed in C.S.S.D.

1 Bowl (disposable)
2 Receiver (disposable)
3 Douche can
4 Gallipot (disposable)
*5 Artery forceps
6 Measure
7 Bladder syringe, Canny Ryalls
*8 Scissors
*9 Clip removers
*10 Dissecting forceps (in packets of 4)
11 Spigot
12 Gate clips
13 Rubber tubing in 2′ lengths
14 Glass connections
15 Safety pins
*16 Probe
*17 Sinus forceps
18 Catheters
19 Funnels for enemas
20 Douche nozzle
21 Cuscoes vaginal speculum
22 Sims vaginal speculum
23 Rampleys sponge holders 7″

* *in aluminium container*



A dressing trolley, showing the contents of pack on the sterile field. The bags clipped to the rail with ordinary household pegs will take dirty dressings, dirty instruments, and any equipment not used

USE OF PACKS

Procedure	*Packs and Articles required*
Ordinary dressing	Pack no. 2 and 4 forceps
Extensive dressing	Pack no. 1 and 4 forceps
Removal of sutures	Pack no. 2 and 4 forceps and scissors
Removal of clips	Pack no. 2 and 4 forceps and clip removers
Injections	Pack no. 5 and atomiser and syringe
Vaginal swabbing	Pack no. 3 and 1 bowl
Vaginal douching	Pack no. 3 and douche can, rubber catheter, measure and receiver
Perineal Dressing with vaginal swabbing	Pack no. 3 and extra gallipot
Catheterisation	Pack no. 3 and extra gallipot, spigot, catheter and receiver
Drips	Pack no. 2 and artery forceps and extra gallipot
Paracentesis	Pack no. 2 and 4 forceps, gallipot, measure and receiver
Lumbar puncture	Pack no. 2 and manometer and needles
Aspiration	Pack no. 2 and measure and gallipot
Haemorrhage	Haemorrhage pack (1 roll 6″ × 6 yd. gauze)
Packing of sinus	Pack no. 2 and ribbon gauze and sinus forceps

Polish Visitors

FIFTEEN Polish public health nurse administrators will spend ten days in March observing the administration of public health nursing services in England. The Queen's Institute has arranged a programme which allows for the Polish visitors to divide into three groups. One group will visit East Sussex, another Birmingham and Warwickshire, and the third, under the guidance of Miss E. M. H. Johnston, Queen's Visitor, will visit Lancashire and Liverpool, including the William Rathbone Staff College.

On their return to London, the entire party will spend an afternoon at the Queen's Institute, where they will see the films *Posture and Lifting* and *District Nurse*, and will be entertained to tea by members of the overseas committee and of the staff.

This week on the district is one of three weeks which the Polish nurses are spending in England, under the auspices of the British Council and the National Council of Nurses.

"..... if feet could speak, their comments would be unprintable"

Shoes for Nurses

by **TEMPLE T. STAMM,** M.B., F.R.C.S., L.R.C.P., *Orthopaedic Surgeon, Guy's Hospital, London*

ALL the clothes that we wear are designed to achieve a compromise between the two often opposing considerations of function and appearance. In the case of footwear this compromise is particularly difficult to achieve, since the shoe must form the outer covering of a most complicated, and hard-worked, piece of machinery.

Our feet were designed as machines for active propulsion, but under conditions of modern civilisation we use them as portable pedestals on which to stand or trudge about on the hard and unnatural surfaces of floors and pavements. They thus are subjected to continuous strain, but they do not get the exercise of their muscles which would enable them to withstand such unnatural and prolonged strains. Those of us, therefore, who must stand for much of the day, need shoes that will give some support to the foot so that even if the muscles do get tired they will not be subjected to undue strain. Hence the necessity for working shoes which have a job to do, as opposed to shoes for social occasions when appearance is rightly the primary consideration.

What then are the criteria for a good working shoe? It is impossible to lay down hard and fast rules, especially as no two pairs of feet are exactly the same, but it is possible to define the essentials in a general way.

A low heel tends to throw the strain of weight bearing on the long arch region of the foot, whereas a high heel throws the weight on to the forefoot. Compromise is therefore necessary and one should find out by experiment which height of heel suits one's own feet best. But do not fall into the error of imagining that because shoes have low heels they are necessarily "sensible". In fact, one well-known surgeon said that if he were only allowed to adopt one measure to relieve foot-strain, he would choose to raise the heels of all shoes by half an inch. But that is no excuse for four-inch stiletto heels. Generally speaking a 1½–2-inch heel suits most women.

The Shank

This is the part of the "undercarriage" of the shoe which extends from the heel to the ball of the foot. It should be strong but should also have a springy resilience. Test it by placing the shoe on the floor and trying to depress the shank with the thumb. It should give only slightly with firm pressure and spring back when the pressure is released.

Flexibility of the shoe should be at the line of the toe joints, that is, at the junction of the shank with the sole of the shoe, *not* in the middle of the shank as is so often depicted in advertisements.

The sole of a shoe should be flat and firm, for it should act as a platform for the toes. The disadvantage of the modern substitutes for leather is that they do not retain their shape and tend to curl up at the edges, so that the toes become cramped into a trough instead of lying freely on a flat platform. They are popular because they are cheap, waterproof and long-wearing, but if feet could speak, their comments would be unprintable! Leather also has the advantage that it can absorb moisture and let in air; in other words, it can breathe.

Keeping the Shoe On

The upper parts of a shoe should serve two functions. First, to retain the shoe on the foot. For this purpose they should fit closely round the heel and instep, being held in place by a strap or by laces. A court shoe which has neither depends upon the close fit of its upper rim. If it is perfectly made and fitted it is quite effective, but as this is the most difficult way of keeping a shoe properly in place one should always be prepared when buying a court shoe to take extra trouble and to pay more for it. There is nothing so effective a sal ace-up shoe of the Oxford type, but unfortunately its fashion rating is low.

The second function of the uppers is to provide a protective covering for the toes, while allowing them full freedom of movement. This means that the forepart of the shoe should resemble the shape of the human foot. Since this shape is regarded as being ugly it has to be disguised by adding a false pointed toe-cap. As long as this extends beyond the toes no harm is done, but this makes the foot look longer, which is also regarded as being a bad thing. So usually the toes are forced into a V-shaped cavity which is too short for them and compresses them all together.

Finally, since feet vary very much in their shape, it is impossible for shoes made on any particular last to suit all feet. It is not sufficient therefore to have the right size and fitting; one must also try to find shoes made on a last that is correct for one's particular feet. This may entail a long search but it is well worth while.

The principle rules to follow when buying shoes for working purposes are therefore:

1. Stick to the height of heel that suits you best.
2. See that they have strong shanks but are flexible at the line of the toe joints.
3. Choose leather soles for preference.
4. Make sure that your toes have plenty of room, but that the shoe fits closely around heel and instep.
5. There is nothing to equal a lace-up shoe. If you must wear court shoes be prepared to be extravagant.
6. It is worth making an extensive search for the type of last that suits your particular feet.

The second of four articles on district nursing and allied services in Australia: The Victorian Bush Nursing Association celebrates its golden jubilee this month

In the Victorian Bush

by **EDITH FRANCIS,** S.R.N.
Nursing Superintendent, The Victorian Bush Nursing Association

THE country hospitals of Victoria fall into two quite separate categories run by two different organisations.

The State Government Hospitals are managed by the Hospitals and Charities Commission. This organisation was set up in 1948; its service is administered in twelve regions each centred on a base hospital, each having its regional services—either in being or projected—such as a blood bank, reserve equipment, pathology, radiology, engineering and physiotherapy. Within the region are smaller hospitals, in all nearly ninety, of which two-thirds have less than twenty-five beds.

Besides its general hospitals the Commission administers many charitable institutions including: hospitals for the aged, blind, deaf and dumb; benevolent homes; ambulance services, which were once on a par with the Bush Nursing Association; district nursing services on a limited scale, not extending to the country.

Even in such a small state as Victoria this leaves many habitations far remote from a state hospital.

Filling the Gaps

The Bush Nursing Association is a separate organisation with a long and honourable history which plays an important part in filling these gaps in places where the local people are anxious to help themselves: it enables their efforts to be organised to the maximum advantage and administers the funds which the Government provides in support.

The country hospital service in Victoria is thus a happy partnership of an entirely state-run organisation—the hospitals of the Commission—and subsidised private enterprise represented by the Bush nursing hospitals. It is to the history and organisation of the latter that I wish to devote the remainder of my time.

The Bush nursing movement was conceived in December 1909 by the Countess of Dudley, wife of the Governor-General, who (to quote from the Marian Barrett Memorial lecture of 1955 by Dr. George Simpson, the honorary secretary of the Bush Nursing Association) "in her travels about Australia was quick to appreciate the need for such a service here, and was impressed by what Australia owed to her bush population". She saw the need for a decentralised nursing service in remote areas and enlisted the help of Lord Carmichael, Governor of Victoria, and his lady, of Sir James Barrett, who is really the father of Bush nursing, and Dame Nellie Melba, amongst others.

The first Bush nurse was established at Beech Forest in the Otway ranges in February 1911, so the Association is approaching its golden jubilee. It is interesting to note that the teacher at Beech Forest in "the crude, tiny school", was none other than John Flynn, later to become famous as "Flynn of the Inland". He knew all about Bush nursing in its early days and wrote of it in his publicity magazine *The Inlander*. He was greatly impressed and inspired by Lady Dudley's brain-child, which can thus perhaps claim sibship with the Flying Doctor Service.

At first the Bush nurse operated as a visitor, horse-borne or even camelborne in the northern areas, in fact a district nurse; if the patient was too ill to come to her, she moved into the home. Early on she established a tradition. Local funds found her salary and financed her accommodation, later providing a cottage which was also her surgery and dispensary.

By 1914 twenty such centres were operating, each with its own local committee. Under the original constitution of 1910 a central council of management consisting of representatives of the British Medical Association, the National Council of Women, the Melbourne District Nursing Service, the Red Cross, the Victorian Ambulance Society, St. John's Ambulance Brigade, etc., had been set up in Melbourne with a trained nurse as superintendent, who travelled round visiting the centres. Her salary was paid by a grant from the Walter and Eliza Hall Trust; all other members were honorary.

As the movement grew and spread a number of charit-

Sentry duty outside Ensay Bush Nursing Centre

Two sisters setting out on their daily rounds – with very different means of transport. They work from the Bush Nursing Centres at Dargo (left) and Lockington (right)

able trusts became interested, and soon after the first war it became possible to establish local hospitals where there was the need and local enterprise to do so; this was a natural development of the centres: then a number of small private hospitals in the country joined the Association. In fact, Bush nursing hospitals are still registered as private hospitals under an Order in Council and are exempted from the Hospitals and Charities Act.

Since the last war the Victorian Government has subsidised the Association with grants for both maintenance and capital requirements in increasing amounts, and the central council is responsible for the administration of these funds.

At the present time there are forty-six hospitals and sixteen centres; the hospitals vary from four to twenty beds and nearly 250 trained nurses are employed.

State Grant Augments Fees

Each is managed by its own committee of local citizens; all are co-operative and the subscribers of an annual fixed amount are admitted at a reduced fee when they are sick; hence the income of each hospital is provided by membership fees plus patients' fees plus a maintenance grant from the State Treasury. The amount of the latter is fixed according to local requirements and the average bed occupancy the previous year. The maintenance grant now stands at £80,000 per annum which represents about eighteen per cent of total maintenance costs, balance in the region of half a million.

Nurses are appointed by the superintendent and their salaries are paid regularly every fortnight by the central council so that every Bush nurse is assured of her pay. The central council is reimbursed at monthly intervals by each hospital which has a list of guarantors. The cost per week per patient varies from £40 to £21 and fees to members, in some cases as low as eleven guineas, are usually about two-thirds of the total bed cost to non-members. The hospitals are registered for hospital benefits.

Capital funds for building extensions and for new hospitals are subsidised on a £2 for £1 basis up to a total liability to the Government of £75,000 per annum.

The beneficent Government, in making these funds available to Bush nursing hospitals, relies on the central council to see that they are properly and economically used, and council approval for extensions is only granted when they are considered to be really necessary.

Before any major capital expenses are incurred the local committee must have in hand at least one-third of the estimated cost and submit their plans, which are then scrutinised by the building sub-committee of the council and approved by the full council at its next monthly meeting. The plans are then referred to the department of health and, if approved, building can begin: the Government grant is made available as the contractors' accounts are paid.

If a community desires to build a new hospital, after discussion with the central council it makes formal application for registration stating the proposed number of beds. After registration plans are drawn up; when a third of the cost is available and the plans have been approved building can begin on exactly the same conditions. The Government stipulates that the overall cost must not exceed £5,000 per bed, which includes all necessary services and staff accommodation.

A great deal of ingenuity and local enthusiasm is exercised by local committees in collecting money both for capital improvements and maintenance, and in their various ways the Bush nursing hospitals are most attractive. Radio appeals run by provincial broadcasting stations are very helpful in raising money for the Association.

In addition to gifts to local hospitals, the central council receives numerous donations, legacies and grants from

charitable trusts, and over the years has accumulated considerable funds which it is able to use to the best advantage of the movement. From its resources the council is able to loan considerable sums either at a low rate of interest or interest-free to assist its member hospitals with their developments.

The central council consists of a president and about twenty members, including representatives of various organisations and a number of country members, two of whom are members of the State Parliament, one in each House. In addition, there are two members who are of key importance, one being the university professor of obstetrics and gynaecology and the other the vice-chairman of the Hospitals and Charities Commission. Relations with the Commission are most cordial and free from any rivalry, and its various officers are always ready to give advice on any questions of administration: the two organisations are thus complementary.

The council meets regularly each month to deal with the various problems as they arise. Over the years a great fund of experience has accumulated bearing particularly on the country approach to medical problems and this is available for the benefit of the Association.

Through its hospitals the Bush Nursing Association exercises a number of important functions:

1. It encourages and organises local co-operative community self-help, for the country folk are intensely proud of their hospitals; if all hospitals were State-run this great potential of honorary effort would not be available for the common good. It encourages and assists people to help themselves.

2. It provides 527 hospital beds in places where they are much needed, and the centres save folks many a long trip which would otherwise be needed for minor treatment. Sick country folk are much happier, perhaps recover more quickly among their own people.

3. It plays an active part in the manufacture of new Australians, and the obstetric figures of Bush nursing hospitals are impressive. In 1959, 2,762 women were delivered and there was only one maternal death. In the last thirty years, in 72,131 deliveries ninety-nine mothers have died which gives a figure of less than 1.4 per thousand births; recently it stands at about 0.4 per thousand. The stillbirth rate in 1959 was thirteen and neonatal mortality seven per thousand.

4. It plays an important part in the population and development of rural areas by providing workshops for doctors in country districts, and doctors are very important to the opening-up of new country. When people, especially young people, are offered a job in the country their first question is "How far to the nearest doctor?" and the second, "How far to the nearest school?"

5. Recently staffing problems have been alleviated by the sponsoring of trained nurses from the United Kingdom, so that they can migrate to Australia on the £10 passage. There is no legal obligation to stay in Bush nursing, but even those who do not serve their two years with the Association can be counted an acquisition to Australia. A happy and contented team of nurses is the aim of the Association. Since the welfare of all staff is centrally directed it is usually possible to arrange for nurses to move from one place to another. Friends can work together. Anyone joining the Bush Nursing Association will be making an important contribution to the future of Australia and towards strengthening the ties of the British Commonwealth.

Gardens Film for Metropolitan A.G.M.

"WHATEVER particular function the nurse may have, she is often the link between the statutory services, those of the local authorities and government, and of the voluntary services, all of which must play their part."

This statement, quoted from "Fresh Orientations", by Lord Cohen of Birkenhead, published in *District Nursing* for November 1960, was illustrated admirably at the annual general meeting of the Metropolitan District Nursing Association held at the home on 22nd November 1960.

Among those who attended the meeting, which was presided over by The Right Worshipful the Mayor of the City of Westminster, Councillor Robert L. Everest, were the Mayors of Finsbury and St. Pancras, representatives of the L.C.C., various hospitals, care committees and welfare centres, as well as members of voluntary services. The "link" to which Lord Cohen referred was evidenced by the uniform of the district nurse, which was much in prominence.

In his opening remarks the Mayor read an extract from a letter of appreciation of the work of the district nurse—a letter that was typical of many received at the home from families or friends of patients. Over 90,000 visits had been paid during the year, he said, and 2,071 new cases had come on to the books.

Lady Heald, in moving the adoption of the report, paid tribute to the unsparing efforts of the executive committee, and spoke of her close interest in the regular reports received throughout the year on the work and welfare of the nurses. Mr. Keith, honorary treasurer, appealed for more voluntary funds to supplement the generous grant made annually by the L.C.C.

Following a brief business meeting. The National Gardens Scheme film *The Gardens of Britain* was presented. This beautiful film, showing many of the nation's finest gardens at all seasons of the year, was much enjoyed and was a welcomed innovation at an annual meeting.

Before the assembly dispersed conversation over sherry afforded an opportunity of forging an even stronger link between these various services which are concerned with the welfare of the community in the area covered by the Metropolitan D.N.A.

From the address at the Institute's 1960 annual meeting

Trends in the Care of the Sick in Hospital and in the Community

by **SIR KENNETH COWAN,** M.D., D.P.H., F.R.S.(E.), *Chief Medical Officer, Department of Health for Scotland*

IT is a particular pleasure to have this opportunity of renewing my association with the Queen's Institute of District Nursing. In the past I had the privilege of working on many of the committees of the Institute, mainly those associated with trying to secure a partnership between the Queen's Institute and the local authorities who are responsible for the organisation and operation of the district nursing services.

This afternoon affords me not only an opportunity of renewing old friendships, but also of seeing that the Institute is flourishing and, notwithstanding some recent vicissitudes, is still operating, to an even greater potential than in the past.

It is a very important thing if the domiciliary nursing services are to operate efficiently and effectively, that a great voluntary institution like this should continue to flourish and to work in close and active efficient partnership with the local health authorities in the operation of this service.

Future Opportunities

I am taking this opportunity to speak about trends in the care of the sick in hospital and in the community, and to point out some developments which I think will provide new opportunities for local authorities and for the Queen's Institute of District Nursing in the future.

It is natural that the hospital should occupy a particular and special place in the community, and that, fostered by tradition, the public and to some extent the medical and nursing profession should associate it in their minds with the in-patient treatment of illness and injury. From earliest times communities have either provided, or had provided for them, places where the sick were segregated, where medical care or general care was afforded to them. In the early days this was done by religious communities, later by voluntary endeavour, and more recently the communities themselves have directly provided these services; more recently still, the state has taken a major part in the provision of these hospital services. The bias in the past has been towards the use of the hospital as a centre for the treatment of in-patients, and for it to be a largely self-centred unit.

Of recent years developments and new factors have tended to break down this isolation of the hospital from the community, and to bring the hospital into much closer association with the medical and health services which are provided for the welfare and treatment of people actually living at home. There has been a rapid growth of out-patient services, providing not only consultations for the patients of family doctors, but also providing to a limited extent treatment for patients outside the hospital.

There is now free access for general practitioners in most areas to laboratory services, pathological services, physiotherapy and X-ray services in the hospitals for their patients. They can send a patient direct if these services are provided, enabling the family doctor working in the community to do very much more towards the diagnosis and efficient treatment of his patient.

So the hospital is becoming increasingly identified with the community which it serves, and this has been accentuated by the provision of ambulance services, re-settlement, and domiciliary visits which specialists working in hospital pay now to the homes of the people.

In America, and to a lesser extent in this country, home care schemes for the treatment of the sick have been developed using the resources of the hospital to go into the homes of the people and treat the patients there. This sort of home treatment service has had but a limited success in this country, but it exists, and it is another link between the hospital and the actual community.

At the same time, there are indications of a change in the pattern of care afforded to patients who are suffering from some forms of illness. For example, it has been the practice in the past to treat patients suffering from mental illness and diseases like tuberculosis by admission to hospital, frequently for very long periods; but the use of out-patient clinics and day hospitals is showing increasingly how much can be done for patients suffering from such conditions without the need for hospital admission at all, provided that the consultant physician and the medical staff in the hospital are sustained by an adequate and efficient domiciliary medical service.

Schemes for the nursing of sick children at home are replacing hospital treatment, and as the proportion of old people in the population increases, there will of necessity have to be some extension of the district nursing and the home help services.

Closer Association

In all these things there is discernible a gradual but positive tendency for the hospital and domiciliary services to become more closely associated, for the pattern of treatment in hospital to change to some extent, and for domiciliary home treatment to assume a more important role. This change tends to highlight some of the difficulties inherent in the National Health Service.

Much has been said and written about lack of co-

ordination in the National Health Service. There are, because of the structure of the Service, justifiable criticisms that the three administrative divisions may not always work smoothly and operate to the benefit of the patient. What we have got to bear in mind is that the patient is not interested in administrative values or separation of functions as between one authority and another. He is not a bit interested whether it is the regional hospital board that is responsible for him at one moment, or the local health authority at another, or the executive council at some other time. He merely wishes to have a smooth and continuous progress from the onset of his illness to his eventual complete restoration to health and return to work.

True Team Work

Various expedients have been suggested, and some have been tried, to improve co-ordination, but in the long run it is the individual workers themselves who are responsible for bringing together the resources available to aid the patient. It is through them—the doctors and nurses and voluntary workers—that appropriate care will be afforded and every agency will be used for the alleviation of the condition, and there will be a smooth transfer at every stage of the illness from one agency to the next, so that the patient will not realise that a great body like the regional board has been responsible for him at one moment, or a great county council like the Essex County Council was responsible for him at another moment. All he will know is that he has had a smooth passage without any difficulties or administrative battles.

It may be that as these services—the hospital services on the one hand and those provided in the community on the other—become more closely integrated, as I hope and am sure they will, positive effort will be required to ensure proper co-ordination so that a patient does not notice whether he is being dealt with by one agency or another. But there will be a greater need for adequate knowledge on the part of medical and nursing staff of the kind and of the availability of all the resources required for the total care of the patient.

This may sound trite and commonplace, and the sort of thing one would expect, but we all know that, hidebound as we are by our own immediate responsibilities, we are inclined to say "This is not my business, it is someone else's business". Unless we are genuinely interested in the whole service we may not take the trouble to ensure that we know at least something about the other fellow's job of work.

If the hospital of the future is to be more closely associated with the other health services in the community, and if this trend for looking after the patient at home for many forms of illness is maintained, and possibly increased in the future, certain important considerations about the education and training of the doctor and the nurse emerge.

I want to say a word about the training of the doctor. It will be increasingly important that undergraduate medical training includes instruction and practical work related to the problems of general practice, and that in addition, social and preventive medicine should be included and should form an integral part of the training of the medical student. A great deal is being done in this direction already: many medical schools have already general practice training units so that something is being done to fit the undergraduate medical student for the problems of general practice and community care.

But it is rather with the background, education and training of the nurse to meet the new circumstances that I would like to deal. It has always been desirable that the training of the nurse should be as broadly based as possible, but this has not always been achieved in nurse training schemes. I think it is true to say it has not always been appreciated.

Within the hospital service itself the training of the student nurse need not be circumscribed, but it should be orientated to the total needs of the patient suffering from all forms of illness. The newly qualified nurse should have received education and instruction not only in the immediate nursing techniques to be applied to the patient in hospital, but should have some appreciation of the hospital service as a system, designed to serve the needs of the whole population; certainly she should have a full appreciation of the place of the hospital as a unit in the community health services, and of the importance of the community preventive and nursing services in relation to the hospital.

If the outlook of the student nurse is not to be bounded by the narrow confines of the hospital walls, it cannot be over-emphasised that the illness or disability of the patient does not begin at the time of admission to hospital, nor does it necessarily end upon the patient's discharge from hospital. The student nurse, in her basic training, should therefore have at least some knowledge inculcated as to the many economic and social factors influencing the health and welfare of the individual in his own environment, and certainly she should be instructed in the wider aspects of community health services including those related to the nursing of the patient at home.

Specialised Experience

Within the hospital service, arrangements are already in existence in England and Wales and are under consideration in Scotland, for widening the training of nurses by the secondment of students from general nursing to other types of nursing: secondment to psychiatric units, to obstetric units, to paediatric units, or other specialist forms of nursing, which not only broadens the knowledge of the student but may encourage her eventually to work in these more specialised types of hospital.

Schemes of this nature are not easy to put into practice. They involve a good deal of movement during the nurse's period of training, which is not always easy to arrange, and does not always appeal to the administrative heads of nursing services, including the matron. Adjustments are necessary to the amount of time spent by the student nurse in general medical and surgical nursing. There are disadvantages and difficulties, but I am convinced—and

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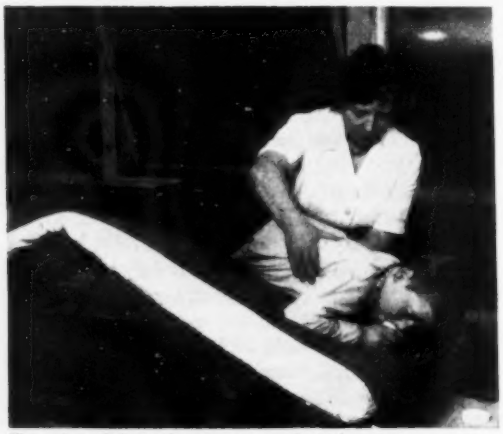
Left: *A typical example of the distress which results from chronic bronchitis. This woman, climbing the stairs, is gasping for breath.* Right: *Living conditions like these are not uncommon in our industrial cities. The incidence of the common cold in families bears a direct relation to the degree of overcrowding, and constant suffering from the common cold in childhood lays the foundation of chronic bronchitis in adult life*



The value of physical treatment: a physiotherapist at an open-air school encouraging a young patient to clear bronchial tubes of mucus

Chronic Bronchitis

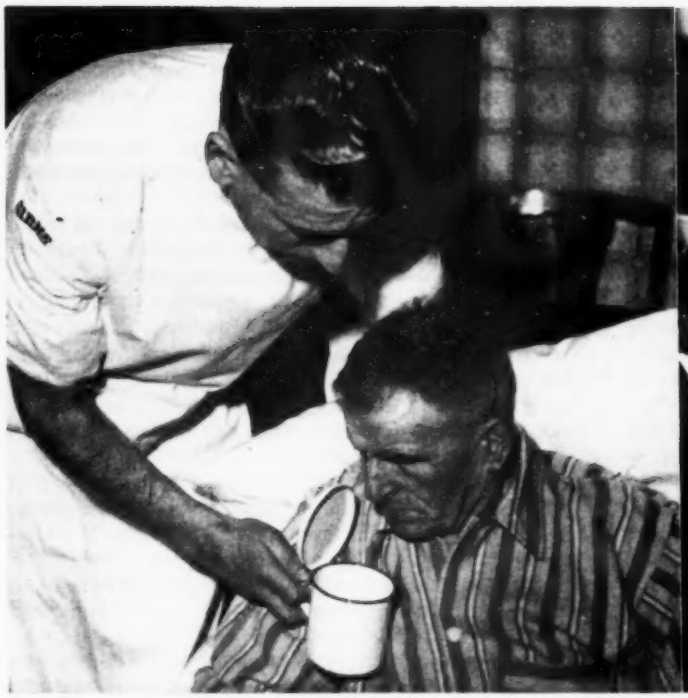
A problem of social medicine which concerns the doctor, the nurse, the social worker, and the leaders of opinion in the community.

This colourful filmstrip (30 frames, 35mm × 24mm) is very well planned and produced. Care has been taken in compiling the notes to make them of help and interest to all concerned with the teaching of students in the health and social services. Appendices give facts and figures which will be of assistance to students.

Adapted from colour filmstrip produced by Diana Wyllie Limited with the co-operation of Pfizer Limited with lecture notes by Dr. J. L. Burn, Medical Officer of Health, Salford, and Lecturer in Public Health, University of Manchester.

Filmstrip and notes price £2, are available from Diana Wyllie Limited, 3 Park Road, Baker Street, London, N.W.1.

An example of chronic air pollution. This photograph was taken on a sunny day in a northern industrial city in the middle of the morning. The horizon is lost beneath a layer of haze caused by domestic and industrial chimneys. Despite the sun the atmosphere is grey and cheerless because the sunshine cannot penetrate, and the sky is never really blue



The district nurse attending to a patient suffering from chronic bronchitis. This patient is not always bedfast but may on some days, depending on the state of the weather, be able to get up and even go out. In some chronic cases the district nurse administers antibiotic injections

The health visitor talking to an elderly patient whom she encourages to visit a special old peoples' clinic for physiotherapy—drainage and relaxation—to help him. Her regular visits to this patient in his home enable her to advise him, not only regarding bronchitis but on any other medical or social problems which he may have

One method of preventing chronic bronchitis in the adult is by preventing respiratory complaints in childhood. Immunisation against pertussis is therefore not only a safeguard during childhood but also against damage to the lungs in later life

Power has been given to local authorities by the Clean Air Act to make smoke control areas where only authorised (i.e., smokeless) fuels are allowed to be burnt. The smoke inspector explains to a householder whose grate requires alteration in order to comply with the Act

Trends in the Care of the Sick

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I think those who are now dealing with this comprehensive form of training are also convinced—that the advantages more than outweigh any difficulties or disadvantages that may occur.

In similar fashion the training of the student nurse is being re-shaped to include instruction in community health, including infectious diseases, and in the public health, preventive and social services of the local authority. Lectures are given to the student nurse, and visits are paid to medical institutes and clinics of the local authority, so that the nurse in training knows that things are happening outside the hospital walls which affect what she is doing in the hospital and will affect the patient when he leaves the hospital.

It is becoming increasingly common for hospital and domiciliary staffs to associate more closely through study days and joint conferences, and by visits to the hospital by the nursing staffs of local authorities; so that something is being done to try to ensure that to meet these trends, at least the nurse's basic equipment as a nurse will be so shaped that she has some general knowledge of these things when she qualifies as a fully-fledged nurse.

I think the ultimate object should be that the nurse develops an attitude of mind which recognises that the home conditions of the patient play an important part in recovery from illness, and that social factors influence the onset of disease, and they must be taken into account in prevention. So that although she works in the hospital all the time with sick people, she realises that outside influences have caused this patient to come into hospital, and the disease may have been preventable. She knows also that services exist to speed the recovery of the patient when he leaves the hospital.

Now these developments in comprehensive training of the student nurse should ensure that in future at the level of the worker in the National Health Service, in the public health service and in the hospital service, there will be sufficient knowledge to ensure that there will be integration in the mind of the individual person, I hope the mind will enable it to be put into practice.

I would like to say a word about important developments in the field of mental health, and in the treatment of mental illness. Both in England and Wales and in Scotland new legislation provides an opportunity for developing the services which are devoted to the care of the patient suffering from mental disorder, and this is primarily so in the services to be provided by the local health authorities. Over the past thirty years there have been very important advances in the treatment of mental illness, and the role of the mental hospital has changed from one of segregation and custodial care, a place where patients were locked away for long periods when perhaps there was a minimum of active treatment, to one where there is a minimum of segregation for the mental patient and the maximum of all sorts of resources for short-term hospital care and of active treatment.

Everything is done to try to ensure that the patient in the mental hospital is treated actively, and stays in hospital for as short a period as possible. There are new drugs, electro-therapy, group treatment, and greater emphasis on voluntary admission of patients. The establishment of open wards rather than locked doors has led to the mental hospital becoming a therapeutic centre with concentration on cure for most of the patients, and active treatment for those chronically ill.

This is a most important development within the hospital field, and has placed the mental hospital on a par with the general hospital in the treatment of physical illness.

There has been another very important development: day hospitals have increased the number of patients who receive daily psychiatric treatment suited to their particular needs while they live at home. This does not only mean occupational therapy, although that is included, but physical treatments are included as well as psychotherapy and group treatment.

One of the important points in a day hospital is that the patient lives at home, and it is claimed that the preservation of contact with the community while he is undergoing treatment constitutes one of the main therapeutic factors, and is a great advantage in inducing patients to take up again the full responsibilities of life at home and life at work.

There is another very important development which goes even further in the domiciliary care of mental disorder, taking place in various parts of the country where the patient remains at home while undergoing active treatment for mental illness. Experiments like those which have been undertaken by Dr. Carse at Worthing where, through his day hospital and through the provision of teams of doctors and other workers going into the homes of the people, he has been able to reduce the admissions to the mental hospital by more than fifty per cent.

Mental Disorder in the Community

In certain parts of the country community services for the care of patients suffering from mental disorder are developing. Joint appointments of psychiatrists have been made between regional hospital boards and local authorities, and there is much closer contact between the staffs of the mental hospitals and those of the medical officer of health, either at special centres or at premises used by the local health authority. This closer integration is again fostered by meetings and case conferences, where patients' difficulties, treatment and after-care are discussed.

Here again, in the actual community as well as in this hinterland where the patients may fall between two or three stools, there is closer integration in mental illness; and again in the hospital there is accelerated active treatment for patients suffering from mental illness.

Perhaps I have dwelt on this rather long, but it seems to me a very good example of what can be done when people associated with a rapidly progressing new form of treatment and care really put their minds to it to ensure that every resource available is used for the care of the patient.

We hope that the new legislation will stimulate and encourage development of community services and will

help to promote this close association which is so desirable between workers in hospitals and in the local health authority services in this field.

It is interesting that two or three years ago the College of General Practitioners, in association with the General Register Office of the Ministry of Health, carried out a morbidity survey into a large sample of the population of this country. A morbidity survey is simply trying to find out what amount of illness there is in the community, and what different forms of illness there are, and out of this particular survey one very striking fact emerged. One in every fifteen patients who consulted their doctor was suffering from psycho-neurosis. That means that in England and Wales (Scotland was not included in the survey) about two million people are undergoing treatment for psycho-neurotic conditions every year. This of course immediately indicates that the general practitioner must equip himself to deal adequately not only with the treatment of these neurotic conditions and the true psychoses, but he should have some knowledge and take part in prevention.

There is a great demand now from family doctors for post-graduate courses where the emphasis is on mental health. The doctors themselves know there is a need for it, and they are anxious that post-graduate courses should be provided where they can get refresher knowledge in connection with mental health.

In the nursing field it is very important that more attention should be paid in post-graduate work and in refresher courses to this subject of mental health, but much remains to be done to create interest in this, and to provide such instruction for nurses engaged in the community health services.

We all know that in the field of prevention local authorities have made and are making major contributions to the elimination of many fatal and crippling conditions. A few years ago almost 3,000 people died every year in this country from diphtheria. It is largely as a result of the work of local authorities and their staffs that this disease has now been, perhaps not eliminated, but at least the figures of mortality now never reach double figures. In the same way with poliomyelitis, through the work of the local authorities a great deal is being done already through vaccination to reduce the number of cases, and with new vaccines it may eventually be eradicated altogether.

Concurrent with these spectacular results and others in the field of infectious disease, there have been remarkable changes in the mortality amongst infants and young children. Infant mortality in the past forty years has been reduced five-fold. There has been a great improvement in the health and nutrition of the infant and of the child at school. The local authorities and voluntary organisations who work with them can take a great deal of credit for this improvement. Their medical and nursing staffs have done a great deal of patient work over many years in this field of prevention. I think they can look with pride on this: they have really put their backs into it.

Fresh and Great Responsibilities

But the point I want to end with is that in these other fields that I have mentioned, fresh responsibilities are emerging. In this wider field of the treatment of the sick at home and in the rehabilitation and re-settlement and in the welfare of patients in the community, are great responsibilities.

These trends that I have outlined to you I think present a challenge to those responsible for the organisation of personal and domiciliary medical services in the community. This increasing emphasis on treatment at home, for example, of mental illness, and the work done in physical illness combined with the responsibility for the prevention of disease, and for the after-care of patients, afford to local authorities and great voluntary organisations like the Queen's Institute opportunities for the development of comprehensive services for the promotion of health and for the alleviation of suffering.

The pessimistic suggestions that the Jeremiahs made ten years ago, that local authorities would only play a minor role in the health and medical services in the future and that the need for voluntary organisations would cease, have already proved themselves to be false; my own view is that there is every indication that the community health services will increase and grow in importance in the future.

If this is so, to meet these future responsibilities, local authorities, in association where it is appropriate with voluntary organisations, will require to plan their resources to deal adequately with expanding duties in fresh fields. Doctors and nurses and social workers must be trained and equipped to meet new situations. I think what is most important of all is to inspire confidence in their ability to supplement hospital services by high standards of domiciliary care. In the field of prevention local authorities have done a magnificent job, and in the field of medical treatment they face expanding responsibilities. If this challenge is fully appreciated, I feel sure it will be met with the same vigour and success that local authorities and their associated voluntary organisations have applied so successfully in the field of prevention.

LORD MOYNIHAN

THE Lord Moynihan, whom the Minister of Health has recently appointed as chairman of the North Western Metropolitan Regional Hospital Board, has resigned from the position of honorary treasurer of the Queen's Institute, which he has held since 1949, and from its finance and investment sub-committees.

Lord Moynihan feels that his new appointment will take up most of his available time. However, he has not entirely severed his connection with the Institute, as he is continuing as a member of its council, on which he has served for fifteen years, and of its Parliamentary sub-committee.

While accepting Lord Moynihan's resignation with regret, the Institute has thanked him for his work on its behalf and has congratulated him on his new appointment.

NURSING BOOKSHELF

Women and Fatigue. A woman doctor's answer. By Dr. Marion Hilliard. (Macmillan & Co. Ltd., price 10s. 6d.)

WHAT an excellent little book this is! I liked particularly the forthright way in which it is written—"down to earth and no nonsense" style. And yet it has a message of sympathy and understanding throughout.

There are numerous cases of interest in this well-written book which Dr. Hilliard openly discusses and records, and because they are applicable to almost all women who are asking "Doctor, why am I so tired?" I feel this book is suitable for women of all ages, containing useful, indeed valuable information. It deals with every type of present-day problem arising through the stress and strain of modern living, both from the practical and psychological angle.

I recommend *Women and Fatigue* to all wives and mothers, so sincere is my personal feeling that it should be in every family home.

It is indeed regrettable that owing to the untimely death of Dr. Marion Hilliard, her pen will no longer serve as a medium for the conveyance of such good, sensible literature, which helps thousands to help themselves.

P.V.M.H.

A History of the Nursing Profession by Brian Abel-Smith (William Heinemann, Ltd., price 30s.)

THIS is not a particularly easy book to read, definitely not light reading, but I enjoyed it. I feel it is primarily of interest to those concerned with the administration of the nursing services.

While reading it, I looked back over the years of my own training and experience. It was brought home to me very forcibly how much one accepts in the profession, knowing little of how the standards and conditions we enjoy (?) were achieved. For this reason, I think this book should have a place in the hospital library.

If the student nurse finds little time to read it, and it does take some time to read it through carefully and thoroughly, teaching staff might find some excerpts particularly suitable for, say, group discussion. For example, "... The policy of treating in the home as much sickness as possible was not reflected in the training of the nurse ..." and "... Nurse training is also a preparation for citizenship received by about one girl in twenty. She can gain from it something analogous to what young men gain from National Service, some discipline, some corporate life and some sense of responsibility to the community ...".

The latter quotation comes from a paragraph referring to "so called wastage" in the profession. Wastage and insufficient recruitment for nurse training are problems of today, as they were of yesterday. Those who care about the profession and its attendant problems, will find, I think food for thought in *A History of the Nursing Profession.*

H.H.C.

Textbook for Health Visitors by L. Roberts, B. Corner and C. H. Shaw. (Baillière Tindall & Cox Ltd., price 32s. 6d., postage 1s. 6d.)

FIRST published in 1951, this book has now been revised and brought up to date.

The opening chapters make a good introduction to present-day public health by tracing the development of the various branches of public health nursing. The survey of central and local government gives a clear and concise picture for reference and revision purposes, and the paragraph on the legal aspects of power of entry into private homes and factories is helpful.

It seems a pity that the previous training of the health visitor students has not yet been given a little more consideration, as the omission of various paragraphs on material already known would have enabled the authors to enlarge more on the actual work of the health visitor, e.g. the technique of interviewing, teaching methods, record keeping, and her part in projects and research.

The table showing the development of behaviour from a physical-social aspect is valuable and enables the student to pick out the developmental milestones easily. A considerable part of the book is devoted to infectious and non-infectious diseases which are well covered in general nurse training. The chapter on the National Health Service which forms the framework in which the health visitor operates has been unduly curtailed. The closing chapter on sociology is opening a wide field which would be both interesting and important to the health visitor and seems well worth expanding much more.

The book is concise and easy to read and although not a complete text book for health visitors, it would be a valuable addition to the library of health visitor training centres.

L.H.

Modern Gynaecology with Obstetrics for Nurses (second edition) by Winifred Hector, principal tutor, and John Howkins, M.D., F.R.C.S., F.R.C.O.G., gynaecologist and obstetric surgeon, St. Bartholomew's Hospital, London. (William Heinemann Medical Books Ltd., price 17s. 6d.)

THIS is a stimulating and pleasant book to read and one which I enjoyed. One assimilates knowledge without any effort and without being aware of the fact. So many text books written for nurses are compiled of lists, signs, symptoms, treatment, etc., that this is a very pleasant change.

All the modern treatments, operations and drugs are mentioned, and the authors have explained these in the simplest manner possible. One can almost hear the words being spoken to an interested group of students. I liked particularly the chapters on midwifery. They are very concise, yet nothing essential is omitted in this vast field where so many changes have taken place in recent years. Modern drugs and trends in treatment are included.

It was a pleasure to read the emphasis on the psychological aspect in care appertaining particularly to disorders of the female genital tract, which give rise so often to emotional upsets. The nurse who takes the authors' advice to heart will treat her patients as individuals. She will strive to make a personal contact with each one and seek to find how best she can help her to make the necessary emotional and psychological readjustment.

For the student nurse, this is an easy book from which to study gynaecology. Great detail is given of the medical and nursing care and treatment necessary for specific types of gynaecological patients Detail is given too, of modern gynaecological operations and the instruments necessary for them (these are the only lists in the entire book). There is a chapter on the pre-operative treatment which

is clear and detailed. There is also a chapter on the post-operative care which includes the complications which may occur, their prevention and treatment. Venereal diseases have a chapter of their own, the importance of the recent increase in gonorrhoea being stressed. The student nurse should have little difficulty in understanding the subject matter of this book, as most of the diagrams are excellent, being simple, clear and definite.

For the post-graduate hospital nurse, who wishes to bring her knowledge up to date or to refresh her memory, this book will do both.

Midwives and nurses in the public health field, and health visitors who have perhaps been out of hospital for some time, will find this book of very great value. It will put them in touch with modern treatments. It will give them a greater understanding of modern gynaecology and consequently they will be better equipped to advise these women with whom, very often, they are the first to be in contact. For midwives in particular, it will be of interest from the maternal morbidity angle, and for all those of us who work in the public health field, there is knowledge to be gained from the angle of health education.

Taken all round, this book shows clearly how valuable is the collaboration of a doctor and nurse in writing a book of this kind, the surgical and medical skill of one complementing the nursing skill of the other, to the benefit of the patients. **A.A.B.**

TAKE A WINTER'S WALK BY A WELSH STREAM

GLANRHYDW, Kidwelly, Carmarthenshire

Photograph by courtesy of "The Times"

The wild garden and woodland walks, with drifts of snowdrops, will be open in aid of The National Gardens Scheme, by kind permission of Sir Pryse Saunders-Pryse, Bt., in January and February according to weather conditions. Telephone Kidwelly 27, for opening dates

Infant Welfare Centres—Are they all they might be?

A student health visitor turns a fresh and critical eye to the subject

THE infant welfare centre where I am doing my health visitor practice is a new purpose-built building, simply designed and tastefully decorated. The building is T-shaped; the main hall and administrative office forming the leg of the T, with the various clinic rooms and health visitors' rooms opening onto the cross-piece. There are also a kitchen, sluice-room, toilets and cloak-room along this corridor.

Two types of clinic are run for the under fives: the infant welfare clinic and the toddlers clinic. In both cases, the mothers collect their record cards at the clerk's window on their way through the hall; they then enter the clinic room, hand their card to the nurse, and undress their baby or toddler. The chairs are set out in rows, with plastic bowls for the clothes. The nurse weighs the baby, and then the mother dresses him and waits until the health visitor is free to talk to her. The health visitor and clinic nurse sit at a table, with the scales, at one end of the room. Any mother can see the clinic doctor if she so wishes, and the health visitors refer the mothers whose babies have special problems, or for general check-ups. The clinic doctor is present at every session.

Before she goes, the mother is asked if she needs any welfare foods, and her card is marked accordingly. There is a limit to the amount of each food that the mother can buy at each visit. Quite a number of mothers come for weighing and welfare foods only; they do not stop to see the health visitor or doctor.

Mothercraft talks are given weekly, and the time-table is on view in the hall; there are also various posters exhibited in the hall, and various health pamphlets and publications on a small table, which are free of charge. Immunisation clinics are held twice weekly, and the health visitors advise the mothers when they should attend with their babies or toddlers. The immunisation clinics are run very efficiently by the doctor and clinic nurse.

Cool, subdued and hushed

All clinics at this centre run smoothly and competently; there is excellent co-operation between all members of staff, with no suggestion of a hierarchy; each person has her task to perform, and is allowed to get on with it in her own way, although one feels that the general pattern of the clinic is set on rather conventional, static lines. The atmosphere generally is cool and somewhat subdued. The mothers obviously like coming to the clinic, but conversation amongst themselves is hushed; their only contact with the health visitor for the purpose of advice and health education is when they are having their individual consultation.

Voluntary helpers come regularly to the infant welfare clinics to play with the toddlers, and at some of the sub-clinics they also sell the welfare foods.

Basically, this clinic is an excellent building for the purpose, but its atmosphere is formal, and smacks somewhat of a hospital out-patient department. I think this could be rectified by providing curtains in warm, cheerful colours, and by hanging good pictures on the walls. An excellent scheme for the loan and exchange of well-framed prints operates between schools; it might well be extended to clinics.

The mother should feel that her visit to the clinic is a social occasion, and that the clinic is a social centre; much useful health information will be gained by talking to other mothers with young babies whose problems are similar to her own. I think that rows of chairs are to be avoided; the health visitor could sit in the centre of the room, with the mothers around her, and between seeing the mothers individually she can raise points of feeding, weaning and general infant care in open discussion. This avoids repetition for the health visitor, and helps the mothers to learn from the experience of others; it also means that health education is going on continuously throughout the session in the widest possible sense.

A cup of tea helps to foster a friendly atmosphere, and this could be served half-way through the session at cost price. For a reasonable capital outlay, nursery-school equipment, such as a swing, see-saw and push-pull toys, could be provided for the toddlers in the garden.

A half an hour at the end of each session could be reserved for mothers who wish to see the health visitor privately. Judging by the clinic I know, it seems unnecessary for the clinic doctor to be present at every session; twice weekly might be sufficient. The day and time of her attendances should be posted in the hall.

The test-weighing of babies for one feed is no fair test, and is rarely reassuring for the mother; I think it could be dispensed with completely. The routine weighing of all babies and toddlers at the infant welfare clinic also seems to be a time-consuming and often unnecessary procedure. At best, it is a purely mechanical assessment of progress, sometimes giving rise to anxiety and apprehension in the mother. It can be used to confirm observations, but health visitors could teach the mothers to use and cultivate their instinctive powers of observation and intuition where their babies are concerned, and not rely blindly on written facts and figures, often confusing.

I think it would be easily possible to increase the afternoon activities for mothers, which might in time replace the present accent on weighing and the sale of foods, and give an added incentive for clinic attendance. Mothers should feel that they can freely come and go to the clinic, not only when their babies are to be seen by the health visitor or doctor.

Talks relating to health can be given sometimes by health visitors and at others by invited experts. The

Work as a Geriatric Health Visitor

by **MARY R. PECK,** S.R.N., S.C.M., Q.N. and H.V. certs.

FOR the last five years, I have been employed by the Surrey County Council as geriatric health visitor attached to St. Luke's Hospital, Guildford, which contains a geriatric unit.

I start my day at the Queen's nurses home, where I am able to see the district nurses before they start out on their rounds. This, I think, we all find useful, as our work is so interlaced and personal contact is by far the easiest way of communication. I stay there for a time, in order to receive telephone calls and do some of my clerical work.

As a routine I visit the almoners of both the Guildford hospitals most days, and the organiser of the W.V.S. and Old People's Welfare Committee weekly. There are of course, many other visits to the general practitioners, local authorities, etc., and meetings to attend as the occasion arises.

I attend the geriatric clinic at the hospital where the patients and their relatives are seen by the physician. The patient is then either referred to one of the special departments for treatment; or put on the waiting list for admission for short or long stay periods, in order to give him specialised treatment and change of environment, and his relatives a well earned rest; or returned home to the care of his general practitioner with suggestions as to home care.

It is also hoped to start a day hospital shortly with two purposes in view. Firstly, in order that patients being discharged after a long spell in hospital may be brought back to continue treatment daily at first. In order that both they and their relatives may become more gradually accustomed to the difficulties of the homecoming, the attendances will gradually decrease. Secondly, patients will attend one fixed day weekly, in order to give them a change of environment and to receive treatment; this will also leave the relatives free to go shopping or have some form of relaxation themselves.

Listening and Listening

The greatest part of my work, of course, consists of visiting in the homes, the majority of my calls coming through the general practitioners and the almoners of the hospitals. The problems are great and most of my time is spent in listening. It is quite amazing what help one can get if one knows to whom to apply for a particular need.

Apart from the statutory bodies, there seems a real growing sense of willingness to help, and feeling of responsibility towards the elderly, by the various church denominations, business houses and local charities, who are beginning to realise the difficulties that our present generation of elderly have to face. They will often contribute towards, say, a holiday for the wife, while the husband is in hospital; or extra comfort in the home that does not count as an essential, such as a fireguard, for which the National Assistance Board would be approached if they were making a weekly allowance.

I deal on the whole with the sick elderly and their problems. The health visitor, of course, also spends a tremendous lot of time in visiting the elderly and so between the district nurse, the health visitor and myself, a close link is formed in home geriatric visiting.

I think "universal aunt" would be a good description of my work. I never know quite what is going to be expected of me. So often these old people have antiquated equipment and in this respect I have great sympathy with the home helps, for often the tools with which they have to work are quite out-dated.

I was asked one evening to light a very old lamp in the bathroom of an old bedridden lady, whose neighbour was away for the night. I did not like leaving it but took every precaution I could think of against its flaring up so much; when I paid an early visit next morning, I found it was out, I was most relieved to find the water was not frozen, or else I knew I should have been in serious trouble with the old lady downstairs.

continued from previous page

following subjects come to mind: talks on cosmetics and care of the skin, given by a representative from a reputable firm; diet and exercise for fitness and figure; simple cookery, recipes, budgeting, good-housekeeping; make-do and mend classes; hand-work in the home; knitting machine demonstrations; the use of electrical household equipment and labour-saving devices.

Fathers should be encouraged to take part in evening activities, but these activities must be widened beyond the confines of orthodox health education in order to be stimulating and worthwhile. The health visitor must initiate activities, but once enthusiasm has been roused a parents' committee could be formed to take responsibility. Some fathers may be persuaded to talk about their work, hobbies, holidays and travel abroad; the practically-minded men may like to give demonstrations of do-it-yourself furniture-making and home decorating. Talks could be arranged on such subjects as child psychology, human relations, the social services, and preparation for school. There could be talks on religion by various denominational representatives.

The infant welfare centre should be a focal point in the neighbourhood, not only for the dissemination of health education and social advice, or the prevention of disease, but for education in living.

Helen White.

TRAVELLING SCHOLARSHIPS FOR SCOTTISH NURSES

Opportunity to Study in Finland

Three scholarships of £150 each are offered by the Scottish branch of the Chest and Heart Association to enable suitably qualified nurses to spend four weeks from 15th May 1961 in post-graduate study of chest and heart diseases in hospitals and clinics in FINLAND.

The offer is open to all registered nurses, including nurses on the Roll of the Queen's Institute of District Nursing and health visitors, working at the time of application in Scotland.

Applications should be made by letter stating age, qualifications, previous experience and reasons for wishing to do postgraduate work in chest and heart diseases. Applicants are requested to state whether leave of absence, with pay, would be granted if awarded a scholarship or if they would be prepared to include the study tour in their normal annual leave.

Applications should be sent to the Scottish Secretary, Chest and Heart Association, 65 Castle Street, Edinburgh 2, not later than 15th March 1961.

The Chest and Heart Association reserves the right, in the absence of suitable applicants, to withhold the award of scholarships.

CHRISTMAS PREPARATIONS
GIFTS FOR LESS FORTUNATE COLLEAGUES

Elderly and sick nurses are not forgotten by the Queen's Institute at Christmas time.

From a special fund, parcels in gaily-patterned paper were sent this Christmas to one hundred and fourteen district nurses. The parcels contained shortbread, chocolate biscuits, Ovaltine, Bournvita, tea, handkerchiefs, soap, talcum powder, lavender water and, for a few in real need, warm winter underwear.

Our photograph (specially taken by Miss A. M. Englefield) shows Mrs. R. Smeeton and Miss I. M Hicks, both retired administrators, consulting the general superintendent, Miss Gray, about the contents of the parcels they are packing

Photograph by courtesy of Universal Pictorial Press & Agency, London

INVESTITURE FOR CRADLEY NURSE

Miss Dorothy A. Boucher, district nurse/midwife at Cradley, near Malvern, Worcestershire, after receiving the M.B.E. at an investiture at Buckingham Palace. With Miss Boucher are her sister and niece

Association of District Nurses

THANKS FROM MISS BLACK

I AM unable to write individually to all my kind friends who contributed to the wonderful present I received from so many members of the Association of District Nurses, for I have not got everyone's address. I hope you will see this and accept my grateful thanks.

I have ordered a beautiful standard lampstand to be made to my wishes and there will be money over for one or two other luxuries.

I am now very busy with my new work, putting all my efforts into making a happy home for seventy-five elderly blind men and women. If any of you are in Worthing I shall be very glad to see you and show you round the home.

The Armitage,
Marine Parade,
Worthing

Augusta Black

Personnel Changes

APPOINTMENTS

Superintendents, etc.

Reid, Mrs. A., Asst. Supt., Burnley—Reeson, Mrs. R. L. A., Asst. Supt., St. Olave's.

Nurses

Bousfield, R. H., Glos.—Cobrey, A. T., Yorks. W.R.—Davidson, D., Shoreditch & Bethnal Green—Fitzgerald, M. E., Kilburn & West Hampstead—Hatt, Mrs. A., Kent—Johnson, Mrs. J. M., Surrey—Miles, B.M., Yorks. N.R.—Morton, M. C., W. Sussex—Murphy, P. B., Bucks.—Rogers, L. K., Hants.—Savage, Mr. S., Southampton—Smith, A. M., Plymouth—O'Donnall, Mrs. J. A., Cheshire (incorrectly listed last month as A. N. O.)

LEAVE OF ABSENCE

Ashworth, M., personal (extension)—Collman, P. A., H.V. trg.—Eagle, D. M., mid. trg.—Laceby, L., mid. trg.—Lamb, R., mid. trg. (extension)—Lenton, A., H.V. trg.—Phelps, E., H.V. trg.—Ward, M. L.—H.V. trg.—Willis, E. M., mid. trg.

RESIGNATIONS

Anson, N. C., retirement—Attridge, I. L., other work—Blunt, Mrs. V. C., other work—Broadbent, Mrs. J., personal—Brooks, C., retirement—Butler, C., promotion—Clarke, E. A., retirement—Collings, D., personal—Cox, E. A. J., H.V. trg.—Curry, E. A., work abroad—Edwards, E. M., other work—Griffiths, Mrs. C. M., personal—Grubb, Mrs. D. J., personal—Hails, W., health visitor—Heap, Mrs. A., personal—Ley, B. R., personal—Line, E. P., personal—Lloyd, A. M., other work—McManus, M., health visitor—McSherry, V., retirement—Mason, Mrs. E. M. M., personal—Norwood, Mrs. M., other work—Nuttall, Mrs. B., personal—Owen, Mrs. N.—other work—Pearson, Mrs. F., retirement—Pearson, J., personal—Petty, L. M., retirement—Reece, S. E., personal—Riddell, E. M., H.V. trg.—Sage, Mrs. D., personal—Smith, M. E., other work—Springham, C., retirement—Wass, Mrs. D., personal—Wilson, M., retirement—Woodard, E. L., retirement.

Scottish Branch

APPOINTMENTS

Nurses

Anderson, M. I., Walls—Ashley, L., Inch—Brebner, M., Fettercairn—Christie, M. C. Kilmarnock—Dalzell, A., Locherbriggs—Higgins, M. G., Portobello—MacKinnon, A., Blackridge—Mason, C. M. E., Kilsyth—Porter, C. C., Portobello—Stephen, A. S., Lerwick—Urquhart, E. J., Sanday—Urquhart, H. E., Fordoun.

REJOINERS

Prentice, Mrs. A. A., Motherwell.

RESIGNATIONS

Bradshaw, E. E., Ayr, retired—Donald, E., Fettercairn, retired—Lindsay, Mrs. M., Kilmarnock, home reasons—MacLean, C., Kilmacolm, hospital post—Macleod, A., Stevenston, retired—Moran, M. T., Edinburgh, midwifery tr.—Sorbie, A. C., Hartwoodhill, retired—Webb, Mrs. E. J. (*née* Bonnar), Dundee, through marriage.

HOME SAFETY

The Mayor and Mayoress of Kendal and Miss Audrey Varley, chairman of the Kendal & South Westmoreland Home Safety Committee, better known to our readers as deputy superintendent nursing officer for Westmoreland, with some of the prizewinners at an exhibition held at Kendal Town Hall

LONG-SERVICE MEMBER OF Q.I. STAFF LEAVES

THE Queen's Institute has lost one of its oldest—in terms of length of service—members of headquarters staff with the resignation at the end of last year of Mrs. Edith C. Messent, assistant to the accountant.

Mrs. Messent joined the Queen's Institute straight from school thirty-four years ago, and has spent most of these years working in the accounts department, latterly devoting much of her time to the administration of the long-service fund. She was awarded the 21 years' administrative service badge in 1949.

The Institute has presented Mrs. Messent with a cheque for £100 in appreciation of her long years of devoted service, and has extended to her its good wishes for the future.

obituary

Mrs. Jemima Calder

THE sudden death on 29th November 1960 of Mrs. Jemima Calder, as the result of a motor-car accident, is recorded with regret. Mrs. Calder was Queen's nursing sister at John O' Groats.

Before her marriage in 1941, Mrs. Calder worked as a Queen's nursing sister in the Galston area, Ayrshire, for one year. She rejoined the Institute in May, 1945, and served in Caithness, in the Dunnet and Keiss areas, until November 1959, when she transferred to John O' Groats.

Mrs. Calder gave commendable service as a Queen's nursing sister and was much respected by all.

Miss Helen Hall

MISS Helen Hall died at Brighton on 30th August. Many Queen's nurses will remember Miss Hall as superintendent of the nurses' home in Bow Road, East London.

I was on her staff just before her retirement about 1935, and remember those years as some of the happiest of my career. She was a wonderful woman and a fine superintendent: there was always a kindly word of wisdom from her in times of difficulty, and she really "mothered" her staff. Her letters reached me several times a year over all these years—even through the ever-changing conditions and addresses of the war years.

The last years of her life were spent in suffering from arthritis, but she remained brave and cheerful to the end, and has now gone to a very well earned rest — dearly remembered by many Queen's nurses. **A.B.A.**

Mrs. Ruby Murray

WE report with regret the death on 13th December 1960 of Mrs. Ruby Murray (*née* Caine), following a road accident while on duty on 8th December. Mrs. Murray died in hospital without regaining consciousness.

Mrs. Murray was undertaking part-time duties in the Runcorn area, Cheshire, where she had been working for the past two years. After taking her Queen's training in 1945/6 in Liverpool, Mrs. Murray stayed on there for a year and then worked in the Widnes area from 1947 to 1949. She will be sadly missed by her colleagues and patients. **I.N.V.**

CLASSIFIED ADVERTISEMENTS

Advertisements for this section can be received up to first post on the 2nd of the month for publication on the 10th. They should be sent direct to: District Nursing, 57 Lower Belgrave Street, London, S.W.1. Telephone Sloane 0355.
Rates: Displayed Setting: 17s. 6d. per single column inch: £2 per double column inch. Personal, 2½d. per word (minimum 12 words, 2s. 6d.): all other sections, 3d. per word (minimum, 12 words 3s.). Ruled border 5s. extra

HERTFORDSHIRE COUNTY COUNCIL

(Member of Queen's Institute of District Nursing)

District Nurses' Training Home, Watford

Senior nurse Queen's trained, preferably with Health Visitor's Certificate, required; capable of assisting in the training of students for the Queen's Institute and the National Certificates.

Assistant Divisional Nursing Officer

Applicants must hold the following qualifications: S.R.N., S.C.M., Health Visitor's Certificate, and have done District Nurse Training, or be willing to undertake this. Valuable experience for those wishing to obtain senior posts. Salary £685 × £35 to £860.

For forms of application apply:
The County Medical Officer
County Hall,
Hertford, Herts.

WARWICKSHIRE COUNTY COUNCIL

Area Nursing Officer

Applications are invited for the appointment of an Area Nursing Officer to work in the Bedworth Urban District and the Atherstone Rural District.

The officer appointed will be required to assist in the supervision of health visiting, midwifery, general nursing and school nursing. Applicants must be qualified to act as non-medical supervisor of midwives in accordance with the Midwives (Qualifications of Supervisors) Regulations, 1937. Previous administrative experience desirable.

The present salary scale is £805 × £30—£955 per annum in accordance with the Whitley Council recommendations.

The appointment will be subject to the Local Government Superannuation Acts, 1937–1953, and to the production of a satisfactory medical certificate. Consideration will be given to the granting of financial assistance towards removal expenses.

Full particulars and application forms (which must be returned by 17th January 1961) can be obtained from the County Medical Officer of Health, Shire Hall, Warwick.

Shire Hall, Warwick. L. EDGAR STEPHENS, Clerk of the Council.
20th December 1960.

CITY OF OXFORD D.N.S.

Queen's Nursing Sister for general nursing only. Resident or non-resident, car driver or cyclist. Consideration is being given to the possibility of attachment of a nurse to a general practice.

Student Queen's Nurses. Vacancies for S.R.N., S.C.M.'s to take three months' course of district training commencing May and September 1961.

Applications to Superintendent, 39–41 Banbury Road, Oxford.

CITY OF SALFORD HEALTH DEPARTMENT HOME NURSING SERVICE

Appointment of Temporary Assistant Superintendent

Applications are invited from experienced Queen's Nurses for this appointment.

Experience in training students for admission to the Queen's Roll will be an advantage.

Salary and conditions of service in accordance with Whitley Council recommendations £675—£800. Commencing salary will be determined by previous experience.

Furnished flatlet available at low rental if required. Car allowance.

Application forms may be obtained from the Medical Officer of Health, 143 Regent Road, Salford, 5.

NORFOLK COUNTY COUNCIL

Vacancies now exist in the following areas:

District Nurse/Midwife/Health Visitor

Blofield. Pleasant rural area 7 miles Norwich. Furnished accommodation for time being.
Downham Market. 2 miles North Norfolk coast. Nurse's house available.
Dickleburgh. Near Diss. Furnished accommodation.
Feltwell. Adjoining Fen area. Nurse's house available.
Hockham. Near Thetford. Rural and beautiful. Nurse's house nearing completion.
Neatishead. Vicinity of Barton Turf Broad. New nurse's house being built.
Raveningham. 10 miles Norwich. House provided.
Stoke Holy Cross. 5 miles Norwich. Attractive countryside. House provided.

District Nurse/Midwife

Cayton. Near King's Lynn. House available.
Thetford area. Relief Nurse.
Wymondham. 9 miles Norwich. 2 required. House provided or arrangement to live separately.

District Nurse

King's Lynn. Male Queen's nurse. Possibility of Council house.

Nurses should be motorists and may use their own cars (loans available for purchase) or cars can be provided. Assistance given to applicants who require driving tuition. Houses furnished if required.

Grant towards moving expenses will be paid.

Staff needed for relief duties, holidays and longer periods—must be mobile.

Applications forms from County Medical Officer, 29 Thorpe Road, Norwich, Norfolk, NOR 01T.

Health Visitor Scholarships

Facilities available for Health Visitor training for full-time and generalised appointments.

Queen's Nurse Training

Courses arranged for State Registered Nurses (usually with S.C.M. Certificates) for work in the County.

CUMBERLAND COUNTY COUNCIL

(Affiliated to the Queen's Institute of District Nursing)

(1) **Health Visitors for West Cumberland**
- (*a*) *Whitehaven* — One required. Combined duties.
- (*b*) *Cleator Moor*—One required. Combined duties.

(2) **District Nurse/Midwife/Health Visitors**
- (*a*) *Wigton*—One required.
- (*b*) *Greystoke* (Ullswater area)—One required.
- (*c*) *Ireby*—One required.
- (*d*) *Alston*—Two required.
- (*e*) *Threlkeld* (near Keswick)—One required.

(3) **District Midwife for Millom**—One required. New flat available shortly.

Cars will be provided for all the above appointments. District training will be an advantage in all cases except under (1).

(4) **Queen's District Training**—Applications are invited from nurses S.R.N., S.C.M., wishing to work as district nurse/midwives in Cumberland. Arrangements can be made for them to take three or four months' training at an approved Queen's Nurses' Training Home.

Further particulars and application forms obtainable from the County Medical Officer, 11 Portland Square, Carlisle.

SOMERSET COUNTY COUNCIL

(Midwifery and Nursing Services)

Health Visitor—Yeovil. Duties consist of maternity and child welfare and school work in borough. To work in group of four health visitors.

Combined Posts—S.R.N., S.C.M., H.V. (Queen's Nurses preferred) or willing to train. Motorists essential. Cars available. Financial help given with driving tuition.

Highbridge—Adjacent to Burnham-on-Sea. Two nurses required. Compact small house available, furnished or unfurnished.

Bleadon — Adjoining Weston-super-Mare. Single district. Accommodation available, house to be built later.

Minehead—On coast in lovely part of Somerset. Vacancy for two. Attractive house, furnished or unfurnished. Cars provided.

Nurse/Midwives required, S.R.N., S.C.M., preferably with district training. Cars available.

Clevedon — Near Bristol. Own living arrangements.

Montacute—Relief nurse for group of four nurses. Accommodation available, house to be built later.

For further particulars apply to: County Medical Officer of Health, County Hall, Taunton.

HEREFORDSHIRE COUNTY COUNCIL HEREFORD

District Nurse/Midwife or District Midwife for duties in pleasant urban area. Modern house, furnished or unfurnished. Motorist or cyclist.

Application forms and terms of appointment may be obtained from the County Medical Officer, 35 Bridge Street, Hereford.

Other Advertisements on p. 244

CITY AND COUNTY OF NORWICH

District Nursing Service

State Registered Nurse required (whole- or part-time), preferably Queen's trained. Whitley Council's scale salary. Car allowance provided. For particulars apply to the Medical Officer of Health, 68, St. Giles's Street, Norwich, NOR 22E.

CANTERBURY DISTRICT NURSING ASSOCIATION

District Nurse required. Male or female. S.R.N.; Queen's trained preferred. Whitley Council scale. A car allowance at essential user rate (not exceeding 10 h.p.) is payable. Applications with the names of two referees to the Medical Officer of Health, 14, Dane John, Canterbury, as soon as possible.

S.S.A.F.A.

Soldiers', Sailors' and Airmen's Families Association

Overseas Nursing Service. Interesting posts for S.R.N./S.C.M. with Q.I.D.N. and/or H.V. certificates. Public health nursing undertaken among families of British servicemen. Apply: Principal Nursing Officer, S.S.A.F.A., 23 Queen Anne's Gate, Westminster, S.W.1.

WESTMORLAND COUNTY COUNCIL NURSING SERVICES

Arnside. District nurse/midwife/health visitor required for this small coastal resort in South Westmorland. House and car provided.

Levens. District nurse/midwife/health visitor required for rural area in South Westmorland. House and car provided.

Kendal. Health visitor/midwife required—one of two undertaking this work. House and car provided.

For further details and application forms apply to County Medical Officer, County Hall, Kendal.

ARGYLL COUNTY COUNCIL

Argyll County Council invite applications from nurses for appointment as District Nursing Sisters at:

Ardrishaig. Vacant 31st December 1960.

Kilmun. Vacant 29th January 1961.

Bowmore (Isle of Islay). Vacant at a date to be arranged.

Fully furnished houses provided and cars supplied.

Further particulars may be obtained from County Medical Officer, Health and Welfare Department, Oban, to whom application should be made.

QUEEN'S INSTITUTE OF DISTRICT NURSING

William Rathbone Staff College

Course in Community Health Administration

Applications are invited from General State Registered Nurses who are (a) district nurses, midwives or health visitors with at least three years' experience in the field; or (b) hospital sisters with at least three years' post-certificate experience who wish to gain a wider knowledge of public health nursing, for the Course in Community Health Administration beginning on Wednesday, 12th April, 1961. **Scholarships are available for nurses from Co. Durham, Sunderland, London and other areas.**

Further details may be obtained from The Principal, William Rathbone Staff College, 1 Princes Road, Liverpool 8.

QUEEN'S INSTITUTE OF DISTRICT NURSING

Health Visitor and District Nurse Training Courses

1961–1962

Health Visitor Course.

1. Nine months' course approved by the Minister of Health to prepare students for the health visitor's examination of the Royal Society of Health. Courses are held at the Bolton and Brighton Technical Colleges and begin in September.

District Nurse and Health Visitor Course.

2. Courses covering thirteen months to prepare students for:

(*a*) The national certificate of the Ministry of Health and the certificate of the Queen's Institute (district nursing).

(*b*) The certificate of the Royal Society of Health (health visiting).

Three months' course in district nursing is taken at approved centres, beginning May/June 1961, and may be followed immediately by nine months' health visitor course beginning in September 1961.

Further information and details may be obtained from the organising tutors at:

1. Bolton Technical College, Manchester Road, Bolton;

2. Arts and Social Studies Department, Brighton Technical College, 237 Preston Road, Brighton.

GLOUCESTER DISTRICT NURSING SOCIETY

Domiciliary Midwife wanted for Part II Midwifery Training School.

For particulars apply to: The Superintendent, 14 Clarence Street, Gloucester.

COUNTY BOROUGH OF SOUTHEND-ON-SEA

Student Health Visitors

Tuition grant together with a salary of £491. 5*s*. per annum during training. One year's post-certificate engagement at Whitley Council salary. Free choice of training school. Applications invited for appointment in April next. Applicants must be S.R.N. and C.M.B. (Part I). Particulars and forms of application from the Medical Officer of Health, Warrior Square, Southend-on-Sea.

ARCHIBALD GLEN,
Town Clerk

QUEEN'S NURSES' BENEVOLENT FUND

Founded in 1913 *by Queen's Nurses, for Queen's Nurses*

Minimum subscription FIVE SHILLINGS a year.

OBJECT—To assist financially colleagues who have to give up work owing to illness.

APPLICATIONS for financial assistance may be made for a GRANT, after three consecutive subscriptions previous to going off duty owing to an illness of short duration have been paid, and after salary rights have been exhausted. *OR*

AN ANNUITY, after five consecutive subscriptions have been paid up to time of going off duty, when the illness involves resignation from District Nursing, and the applicant is unable to undertake other work.

SUBSCRIPTIONS should be sent to Miss Ivett, St. Anthony's, Marine Hill, Clevedon, Somerset from whom further details can be obtained.

An Annual Report, with a renewal notice, is posted direct to all subscribers each year.

Nursing